IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7007 3020 0001 4038 8348

February 29, 2012

Max Long, Administrator
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Long:

Based on the survey completed at Walter Knox Memorial Hospital, on February 17, 2012, by our staff, we have determined Walter Knox Memorial Hospital, is out of compliance with the Medicare Hospital **Emergency Services (42 CFR 485.618)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Walter Knox Memorial Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction

for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before April 2, 2012. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than March 22, 2012.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **March 12, 2012**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

WKMH
WALTER KNOX MEMORIAL HOSPITAL

Serving All of Gem County
1202 East Locust Emmett, Idaho 83617
Phone (208) 365-3561 Fax (208) 365-4176

March 9, 2012

Idaho Department of Heath & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

Attn: Gary Guiles, RN re: State Survey 2/17/12

Dear Gary:

As per our conversation earlier today, the completion date for the sections previously listed as 3/27/12 have been changed to 3/22/12.

As regards to the emergency department staffing, the hospital plans to transition to an all RN nursing staff. To that end, the hospital has hired a RN nurse manager who will begin employment 3/26/12. This individual will be a working emergency department manager and as such will be a part of the staffing mix. In April, we will begin orientation an additional RN to the emergency department for night shift.

In the meantime, the charge RN is no longer taking patient assignments. That individual is solely functioning in the role of supervision of the LPN caring for patients on medical surgical as well as providing oversight for each emergency department patient. The charge RN initiates the MSE and assigns the urgency classification on the initial assessment.

Obstetrical services are covered either by a RN on-call or via replacement of the charge nurse by another RN should an OB arrive.

We trust this will address you concerns. Thank you.

Sincerely,

Jonathan Sprecher, RN
Walter Knox Memorial Hospital
Interim Chief Nursing Officer

cc: John Olson, CEO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING _____	C 02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiency was cited during the complaint survey of your CAH. Surveyors conducting the investigation included: Gary Guiles, RN, HFS, Team Leader Karen Robertson, RN, BSN, HFS CAH - Critical Access Hospital DON - Director of Nursing DQM - Director of Quality Management ER - Emergency Room LPN - Licensed Practical Nurse PA - Physician Assistant pt - patient RN - Registered Nurse	C 000	RECEIVED MAR 0 9 2012 FACILITY STANDARDS	
C 200	485.618 EMERGENCY SERVICES The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients. This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and policies, it was determined the CAH failed to ensure emergency care was provided sufficient to meet the needs of 9 of 19 patients (#4, #5, #7, #11, #12, #13, #14, #17, and #19) who presented to the ER seeking care and whose records were reviewed. This resulted in the inability of the CAH to triage patients and to ensure they were monitored while waiting for examination by a practitioner. Findings include: 1. Policies directing ER staff included: a. The policy "URGENCY CLASSIFICATIONS," dated 8/04/10, listed 3 classifications of patients.	C 200	C200 a; The policy "Medical Screening Examination and Emergency Room Record" has been revised to include a statement indicating that only individuals licensed as a RN or higher may determine the classification. Note attached policy at paragraph beginning "qualified medical personnel." Responsible party: Jonathan Sprecher, RN	3/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John N. Olsen | TITLE: CEO | (X6) DATE: 3/9/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 200	Continued From page 1 These included "Emergent," which required immediate evaluation by a physician, "Urgent," which required treatment within 30 minutes, and "Delayed," for which treatment could be delayed 2 hours or longer. The policy did not state which staff could make these determinations or how patients with lower classifications would be monitored until they were treated. In addition, the policy did not include a procedure to explain how these determinations would be made or documented. b. The policy "STAFFING: EMERGENCY ROOM NURSING AND PHYSICIANS," revised January 2010, stated the ER would be staffed 24 hours a day with "...a licensed nurse (RN or LPN) or Certified Paramedic qualified to assist the physician or PA in the care and treatment of patients presenting for medical attention." The policy also stated an RN would be available to the ER at all times "...to supervise nursing activities in the Emergency Room, and provide direct patient care when indicated." This policy did not define the RN's role in triaging and monitoring patients who were waiting to be examined by a practitioner. c. The policy "MEDICAL SCREENING EXAMINATION and EMERGENCY ROOM RECORD," revised October 2011, stated the "Triage nurse evaluates presenting symptoms" when a patient presented to the ER. The policy did not define the qualifications of the triage nurse nor did it define the triage process. The DON was interviewed on 2/16/12 beginning at 3:10 PM. He confirmed the CAH policies did not address triage of patients or how patients	C 200	C200 a continued: The policy "Medical Screening Examination and Emergency Room Record" has been revised to indicate how patients with lower classifications will be monitored until treated under the Urgency Classification (Triage) Section. Responsible party: Jonathan Sprecher, RN C200 a continued: The policy "Medical Screening Examination and Emergency Room Record" has been revised to include a procedure explaining how these determinations will be made and documented. Note attached policy at paragraph beginning "III Procedure." Responsible party: Jonathan Sprecher, RN C200 b: The policy "Staffing Emergency Room Nursing and Physicians" has been revised to	3/27/12 3/27/12 3/27/12

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C 200	Continued From page 2 would be monitored while they were waiting to be examined by a physician or a PA. The ER Director, a physician, was interviewed on 2/17/12 beginning at 1:45 PM. He referred to policies which defined "medical screening examinations" but he was not able to define a triage process for patients presenting to the ER. The CAH had not developed a procedure to triage and monitor patients in the ER who had to wait to be examined by a practitioner. 2. Triage assessments had not been conducted for patients. Examples include: a. Patient #5's medical record documented a 30 year old female who presented to the ER on 1/29/12 at 8:09 PM. She complained of headache, facial numbness, and visual disturbances. An assessment of Patient #5 was documented by the LPN at 8:31 PM. Vital signs were documented at 8:34 PM, including a blood pressure and pulse of 151/71 and 91, respectively. A neurological check, including checking for one sided weakness and facial droop, was not documented. Patient #5 left the hospital against medical advice at 10:11 PM, 2 hours and 2 minutes later. She had not been evaluated by a practitioner. There was no documentation that Patient #5 had been assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation that Patient #5's condition had been monitored by an RN while she waited to be seen by a practitioner.	C 200	include the RN's role in supervising and the triaging of patients in the emergency room. Note attached policy beginning with paragraph "A RN." Responsible party: Jonathan Sprecher, RN C200 c: The policy "Medical Screening Examination and Emergency Room Record" has been revised to include a definition of the qualifications of the triage nurse and a definition of the triage process starting with Section I Policy Statement. Responsible party: Jonathan Sprecher, RN	3/27/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

02/28/2012
FORM APPROVED
OMB NO. 0938-0391

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C 200	Continued From page 3 The LPN who treated Patient #5 was interviewed on 2/17/12 beginning at 9:45 AM. He stated Patient #5 was not seen or assessed by an RN or a member of the medical staff. He confirmed he was not aware of a specific process to triage patients or to monitor them while they waited to be examined by a practitioner. b. Patient #14's medical record documented a 9 month old male who was brought to the ER on 2/13/12 at 7:14 AM with fever and a cough. At 7:20 AM, the medical record documented his temperature was 100.5, pulse was 153, and respirations were 20. No other vital signs were documented. The medical record documented he was assessed by a paramedic at 7:20 AM. The medical record documented he was examined by a physician at 8:50 AM. No documentation was present that Patient #14 received a triage assessment. An urgency classification was not documented. No documentation was present that Patient #14 was seen by an RN or that he was monitored between 7:20 AM and 8:50 PM, one and a half hours. The record was reviewed with the DQM beginning at 2:30 PM on 2/16/12. She confirmed triage and monitoring of Patient #14 by an RN, between the time he arrived and the time he was seen by a physician, was not documented. She also confirmed a policy specific to triage and monitor patients, while waiting to be examined, had not been developed. c. Patient #4 was a 76 year old female who presented to the ER on 2/09/12 at 9:47 PM. She complained of an erratic heart rate, near fainting episode, and shortness of breath. An	C 200	The above revision of policies will be presented to the medical staff on 3/13/12 and the WKMH Board on 3/27/12. The RN staffing has been changed to assure that a RN is free to respond to the ER and patient triage needs. In-services will be conducted regarding the policy revisions for all RN's and personnel who work in the emergency department. General classes will be given by a local medical center to enhance RN triage skills. Each ER chart is monitored daily for compliance with the new policies. See attached ER tracking monitor. Over the next year, WKMH will be transitioning to an all RN staff in the ER. The current triage (Urgency Classification) policy will be transitioned to the current standard endorsed by the AHRQ which is a 5 level classification system.	3/27/12 3/5/12 3/5/12 & on-going Pending Schedule From Facility 3/5/12 On-going Over the Next year Pending Training of ER staff

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C 200	Continued From page 4 assessment was documented by the LPN beginning at 9:57 PM, including a blood pressure of 154/89 and pulse of 69. Patient #4's ER physician was documented as "in to see pt" at 10:55 PM, 1 hour and 8 minutes later. There was no documentation that Patient #4 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation of monitoring by an RN between the LPN's and physician's assessments. The DQM was interviewed on 2/16/12 at 2:27 PM. She reviewed Patient #4's medical record and stated she agreed with the timeframe outlined above. She stated there was no triage assessment, urgency classification, or monitoring by an RN documented for Patient #4. d. Patient #7 was a 66 year old male who presented to the ER on 1/26/12 at 6:31 PM. He complained of sweating, headache, ringing in the ears, and having to drag his left leg for about 3 hours. An assessment was documented by the LPN beginning at 6:55 PM, including a blood pressure of 211/107 and pulse of 83. A neurological check, including checking for one-sided weakness and assessing gait, was not documented. Patient #7's ER physician was documented as "in to see pt" at 7:08 PM, 37 minutes later. There was no documentation that Patient #7 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. The DQM was interviewed on 2/16/12 at 2:25 PM. She reviewed Patient #7's medical record and stated she agreed with the timeframe outlined	C 200		

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C 200	Continued From page 5 above. She stated there was no neurological check, triage assessment, or urgency classification documented for Patient #7. e. Patient #11 was a 35 year old female who presented to the ER on 1/29/12 at 8:32 PM. She complained of severe pain following a seizure. An assessment was documented by the LPN beginning at 9:10 PM, including a blood pressure of 126/82, pulse of 71, and pain score of 7 out of 10. Patient #11's ER PA was documented as "in to see pt" at 10:46 PM, 2 hours and 14 minutes later. There was no documentation that Patient #11 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation of monitoring by an RN between the LPN and PA assessments. The DQM was interviewed on 2/16/12 at 2:55 PM. She reviewed Patient #11's medical record and stated she agreed with the timeframe outlined above. She stated there was no triage assessment, urgency classification, or monitoring by an RN documented for Patient #11. f. Patient #12 was an 84 year old male who presented to the ER on 2/06/12 at 1:51 PM. He complained of left arm numbness and cramping with swelling. An assessment was documented by the LPN beginning at 3:20 PM, including a blood pressure of 175/98 and pulse of 94. A neurological check was not documented. Patient #12's ER physician was documented as "in to see pt" at 4:15 PM, 2 hours and 24 minutes later. There was no documentation that Patient #12 was assessed by an RN or that a triage assessment was conducted. An urgency	C 200		

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C 200	Continued From page 6 classification was not documented. There was no documentation of monitoring by an RN between the LPN and physician assessments. The DQM was interviewed on 2/16/12 at 2:55 PM. She reviewed Patient #12's medical record and stated she agreed with the timeframe outlined above. She stated there was no neurological check, triage assessment, urgency classification, or monitoring by an RN documented for Patient #12. g. Patient #13 was a 64 year old female who presented to the ER on 1/26/12 at 5:26 PM. She complained of slurred speech, diarrhea, frequent falls, and a headache lasting 4 hours. An assessment was documented by the LPN beginning at 5:32 PM, including a blood pressure of 120/78 and pulse of 124. Patient #13's ER physician was documented as "in to see pt" at 6:54 PM, 1 hour and 28 minutes later. There was no documentation that Patient #13 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation of monitoring by an RN between the LPN and physician assessments. The DQM was interviewed on 2/16/12 at 2:55 PM. She reviewed Patient #13's medical record and stated she agreed with the timeframe outlined above. She stated there was no triage assessment, urgency classification, or monitoring by an RN documented for Patient #13. h. Patient #17 was a 1 year old male who presented to the ER on 2/07/12 at 7:01 AM. His parents stated Patient #17 had an unbroken fever	C 200		

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C 200	Continued From page 7 after taking acetaminophen. An assessment was documented by the paramedic beginning at 7:03 AM, including a rectal temperature of 102.8. An LPN assumed care of Patient #17 at 7:04 AM. Patient #17's ER physician was documented as "arrives to see pt. exam completed" at 8:28 AM, 1 hour and 27 minutes later. There was no documentation that Patient #17 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation of monitoring by an RN between the LPN and physician assessments. The DQM was interviewed on 2/17/12 at 11:25 AM. She reviewed Patient #17's medical record and stated she agreed with the timeframe outlined above. She stated there was no triage assessment, urgency classification, or monitoring by an RN documented for Patient #17. i. Patient #19 was a 1 year old female who presented to the ER on 1/25/12 at 3:42 PM. Her parents stated Patient #19 had fallen with resulting bruising to her face. An assessment was documented by the LPN beginning at 3:55 PM, including behavioral indications of pain. A neurological check was not documented. Patient #19's ER physician was documented as "in to see pt" at 4:50 PM, 1 hour and 8 minutes later. There was no documentation that Patient #18 was assessed by an RN or that a triage assessment was conducted. An urgency classification was not documented. There was no documentation of monitoring by an RN between the LPN and physician assessments. The DQM was interviewed on 2/17/12 at 11:27	C 200		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 200	Continued From page 8 AM. She reviewed Patient #19's medical record and stated she agreed with the timeframe outlined above. She stated there was no neurological check, triage assessment, urgency classification, or monitoring by an RN documented for Patient #19. The cumulative effect of these negative systemic practices seriously impeded the ability of the CAH to provide emergency services of adequate quality.	C 200		

02/28/2012
FORM APPROVED

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation of your hospital. Surveyors conducting the on-site visit were: Gary Guiles, RN, HFS, Team Leader Karen Robertson, RN, BSN, HFS	B 000	Please refer to responses and plan of action on Federal report.	
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to, the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty	BB297		

Bureau of Facility Standards

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WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

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BB297	Continued From page 1 areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving toxicology; and (10-14-88) j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: Refer to C 200	BB297		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 12, 2012

Max Long, Administrator
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

Provider #131318

Dear Mr. Long:

On **February 17, 2012**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005424

Allegation: Patients had to wait extended periods of time without being examined by a physician or mid-level provider. The hospital did not provide treatment for and monitoring of patients in the emergency department.

Findings: An unannounced visit to the critical access hospital (CAH) was made on 2/16/12 and 2/17/12. Staff were interviewed. Medical records of 19 patients were reviewed. Policies, staffing schedules, and on call schedules were reviewed. A tour of the emergency department was conducted.

There are no regulations which define time frames for patients in emergency departments to be examined by a provider. However, during busy times, CAHs must have established triage processes in place to assess patients in order to determine who can safely wait to be seen by a provider and who should be examined right away. In addition, CAHs must have processes to monitor patients who are waiting to be examined in case their condition worsens. Triage assessments must be conducted by a registered nurse (RN) who can monitor patients or assign other nursing staff to monitor patients while they are waiting to be examined.

Three policies defined the care of patients who presented to the emergency department. These included "URGENCY CLASSIFICATIONS," dated 8/04/10; "STAFFING: EMERGENCY ROOM NURSING AND PHYSICIANS," revised January 2010; and "MEDICAL SCREENING EXAMINATION and EMERGENCY ROOM RECORD," revised October 2011. None of these policies clearly defined a process to triage patients and monitor them while they awaited examination.

Medical records of 9 patients who presented to the emergency department documented wait times of between 37 minutes and 2 hours and 24 minutes without being examined by a provider. None of these records contained documentation of a triage assessment by an RN. None of these records contained documentation they were monitored by nursing staff in an organized fashion while they were waiting for examination.

For example, one medical record documented a 30 year old female who presented to the hospital on 1/29/12 at 8:09 PM. She complained of headache, numbness in her left face, and visual disturbances. Her vital signs were taken by a Licensed Practical Nurse (LPN) at 8:18 PM and included blood pressure 151/71, pulse 91, respirations 18, and an oxygen saturation level of 98% on room air. The patient rated her pain at 4 of 10. The emergency room was busy and the patient was placed on a gurney in preoperative holding. An LPN was with the patient but no more vital signs were taken. A note by the LPN at 9:55 PM stated the patient wanted to leave against medical advice (AMA). The nursing note stated "STATES HER HA HAS DIMINISHED AS WELL AS THE NUMBNESS. PT STATES THE MAIN REASON SHE WANTED TO BE SEEN IS FOR THE NEW ONSET OF VISION DISTURBANCES WHICH ARE CONTINUING. ATTEMPTING TO HAVE TO BE SEEN BY PA AND GAVE REASONABLE EXPECTATION OF TIME UNDER 10 MIN. PT AGREES TO STAY FOR THAT AMOUNT OF TIME." At 10:11 PM, the LPN wrote "PT SIGNED AMA PAPERS WITHOUT BEING SEEN BY (the physician assistant.)" The patient was in the emergency department for 2 hours and 2 minutes without being assessed or monitored by an RN.

Each of the 9 medical records without triage and monitoring documentation was reviewed by the Director of Quality Management. She confirmed these patients had not received a triage assessment and lacked documentation of monitoring. She also confirmed a policy defining a triage process and monitoring process for emergency patients had not been developed.

Due to the lack of assessment and monitoring of patients by an RN, the complaint was substantiated and a deficiency was cited at 42 CFR Part 485.618-Condition of Participation for Emergency Services. A corresponding state licensure deficiency was also cited.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm